

2009

STATE OF CALIFORNIA
ASSISTED LIVING WAIVER
RCFE PROVIDER HANDBOOK



**2009
Assisted Living Waiver (ALW)
RCFE Provider Handbook**

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1. INTRODUCTION

Welcome and congratulations! You are now a provider for the Assisted Living Waiver (ALW) administered by the Long-Term Care Division, Monitoring and Oversight Section, California Department of Health Care Services. Thank you for joining our team!

As a partner with ALW, we want to make sure you know and understand some of our often-used terms: “DHCS” refers to the California Department of Health Care Services — one of several Departments within the California Health and Human Services Agency (CHHS). The mission of DHCS is to protect and improve the health of all Californians. DHCS staff and contractors are charged to work with residents, providers and communities to make sure quality services are delivered to aged persons and adults with disabilities.

The Assisted Living Waiver, referred to as the ALW, offers Medi-Cal eligible individuals the opportunity to receive necessary supportive services in less restrictive and more homelike settings.

You are an important part of the ALW program. You and other service providers enable residents to maintain independence in their own homes - their units in Residential Care Facilities for the Elderly (RCFEs) or apartments in publicly subsidized housing.

As a licensed RCFE, you will be responsible for providing Assisted Living services to ALW beneficiaries, which includes personal and supportive care services (including assistance with ADLs and IADLs as needed), chore services, medication oversight and administration, intermittent skilled nursing, and social and recreational programming. Along with your ALW residents, you will also work with Care Coordinators, who assist waiver recipients in gaining access to the services they need. You will, of course, be responsible for complying with all licensing laws and regulations, except where waivers have been granted for the purposes of caring for residents enrolled in the ALW.

To improve the readability of this Handbook, resident/residents are usually referred to residents but may also be called clients, beneficiaries, or recipients. For simplicity sake, we have also abbreviated Assisted Living Waiver services by simply saying AL Waiver program or ALW.

2. PURPOSE, BACKGROUND AND PROGRAM-SPECIFIC INFORMATION

A. Overview

(1) Introduction

This chapter describes the California Medi-Cal Assisted Living Waiver (ALW), specifies the authority regulating waiver services, and summarizes the purpose of the program, resident eligibility criteria, and provider qualifications. Information regarding the ALW can be found on the California Department of Health Care Services' (DHCS) ALW webpage

<http://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx>

(2) Enabling Legislation and Legal Authority

The ALW Pilot Project was initially authorized as a three-year demonstration program by Assembly Bill 499 (Aroner) (Chapter 557, Statutes of 2000). The legislation modified Welfare and Institution Code §14132.26 mandating that the Department trial assisted living as a Medi-cal benefit in two settings, RCFEs and publicly funded senior and disabled housing projects. The Assisted Living Waiver has been renewed and approved by the Federal government for five years, 2009 – 2013.

Medicaid Home and Community-Based Services (HCBS) waiver programs are authorized under Section 1915(c) of the Social Security Act and are governed by Title 42, Code of Regulations (C.F.R.), Part 441.300.

(3) Relationship with the Department of Social Services, Community Care Licensing and California Department of Public Health

DHCS partners with the California Department of Social Services' (CDSS) Community Care Licensing Division and the California Department of Public Health's (CDPH) Licensing and Certification Program for the ALW. Participating Residential Care Facilities are expected to adhere to the RCFE regulations specified in the Community Care Licensing's Manual of Policies and Procedures (Title 22, Division 6, Chapter 8). [Note: All of the Manual Letters and Regulations that California Department of Social Services publishes are available electronically on this website: <http://www.dss.cahwnet.gov/ord/PG295.htm>. The Office of Regulations Development will no longer mail out or provide paper copies of Manual Letters and Regulations.

Regulations regarding the admission and retention of individuals requiring skilled nursing facility level of care have been waived for ALW participants. Waivers have also been obtained to facilitate the admission and retention of individuals with certain prohibited health conditions. These topics are

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fully covered in Section 5 of this Handbook. RCFEs are expected to follow all other regulations.

The relationship between an RCFE and Community Care Licensing (CCL) is not affected by the RCFE's participation in the ALW. The CCL Licensing Analyst will continue to be responsible for monitoring the RCFE's compliance with regulations. If an RCFE is sold, no new ALW participants may be admitted into the RCFE until the new owners have been notified by the Department of Health Care Services that they may admit an ALW participant.

B. What is the Assisted Living Waiver (ALW)?

(1) Background

The ALW started as a pilot project in 2005 designed to determine if assisted living services reimbursed by Medi-Cal can be provided cost-effectively and in a manner that assures the safety and well-being of consumers. The pilot project demonstrated effectiveness and has been renewed for an additional 5 years through 2013.

There are two Assisted Living models for the ALW.

- In the first model, Assisted Living services are provided to participants who reside in Residential Care Facilities for the Elderly (RCFEs). In this model, services are delivered by the RCFE staff.
- In the second model, Assisted Living services are provided to participants who reside in publicly subsidized housing (PH). In this model, services are delivered by Home Health Agency staff.

The ALW has been financed using a Medicaid (Medi-Cal) Home and Community-Based Services (HCBS) waiver.

(2) Purpose

The goal of the ALW is to enable Medi-Cal-eligible seniors and persons with disabilities who require nursing facility care, but can be served safely and appropriately outside of a nursing facility, to remain in or return to community settings. This goal is accomplished by providing an assisted living benefit and other services.

(3) Key Program Components

Assisted living meets residents' personal care, support and health care needs while maximizing their self sufficiency and independence and preserving their ability to exercise choice and control. By responding to their individual and changing needs, assisted living supports residents as they age in place.

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Assisted living services are provided to all enrolled residents and are delivered in either a RCFE or in a public housing apartment. ALW waiver benefits also include:

- Care coordination;
- Nursing Facility (NF) Transition Care Coordination services
- Environmental Accessibility Adaptations

All home and community based waiver programs must meet the following two requirements:

- ✓ All enrolled residents **MUST** demonstrate needs that would result in placement in a skilled nursing facility were it not for the provision of waiver services; and
- ✓ The cost of providing care **CANNOT** exceed the cost of care that would have been provided had the resident been a patient in a skilled nursing facility.

C. Who Can Receive Services?

(1) Introduction

The ALW offers eligible persons a choice between entering a "Residential Care Facility for the Elderly **or** receiving necessary supportive services in a Publicly Subsidized Housing (PSH) a less restrictive and home-like setting. Medi-Cal can reimburse providers for services they deliver to eligible Medi-Cal recipients who are enrolled in the ALW and reside in ALW participating sites.

(2) Eligibility Criteria

There are certain eligibility criteria that must be met in order to receive services as an ALW resident. These eligibility criteria are:

- (a) Age 21 or older;
- (b) Enrolled in the Medi-Cal program;
- (c) Have care needs equal to those of Medi-Cal-funded residents in nursing facilities (See Section 3 below);
- (d) Choose to live in an AL Waiver setting as an alternative to a nursing facility. Facilities approved to participate in the ALW must be located in one of the counties providing ALW services as indicated:
 - 2009 - Sacramento, San Joaquin, Los Angeles Sonoma, and Fresno Counties,
 - 2010 – San Bernardino and Riverside Counties,
 - 2011 – Contra Costa and Alameda Counties,

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- 2012 – San Diego and Kern Counties,
 - 2013 – Placer and Shasta Counties.
- (e) Able to be served within the ALW cost limitations; and
- (f) Able to reside safely in a RCFE or PSH setting.

ALW services will not be furnished to individuals who are inpatients of a hospital, Skilled Nursing Facility (SNF), or Intermediate Care Facility for the Mentally Retarded (ICF-MR).

(3) Nursing Facility Levels of Care

There are two types of nursing facilities, those licensed for level A residents and those licensed for level B residents. Nursing Facility A (NF-A) facilities are Intermediate Care Facilities (ICF); Nursing Facility B (NF-B) facilities are Skilled Nursing Facilities (SNF). The level of care (LOC) standards for NF-A and NF-B facilities are governed by regulations found in Title 22 of the California Code of Regulations. You can examine these codes on line at the official web site California Code of Regulations (CCR) <http://ccr.oal.ca.gov>.

The process of determining medical eligibility is often referred to as a level of care determination or LOC. The ALW Care Coordinators determine an applicant's functional eligibility for the program by verifying that the individual meets the level of care determination (i.e., the applicant requires the level of care that is delivered in either a NF-A or NF-B facility). Assessment instruments used to collect data on nursing home and HCBS waiver applicants are focused on obtaining clinical and activities of daily living (ADL) information. The initial evaluation and periodic reevaluations of the need for a nursing facility level of care are conducted to establish that there is a reasonable indication the resident would be eligible for nursing facility placement but for the availability of home and community-based services.

Individuals requiring one of these levels are distinguished as follows:

- (a) Individuals Needing Nursing Facility Level A (NF-A) [22 CCR Section 51120]
- (i) Require protective and supportive care, because of mental or physical conditions or both, above the level of board and care.
 - (ii) Do not require continuous supervision of care by a licensed registered or vocational nurse except for brief spells of illness.
 - (iii) Do not have an illness, injury, or disability for which hospital or skilled nursing facility services are required.
- (b) Nursing Needing Facility Level B (NF-B) [22 CCR Section 51124]
- (i) Require the continuous availability of skilled nursing care provided by licensed registered or vocational nurses.

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- (ii) Do not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.

(4) Residents Who Cannot be Safely Maintained in the Community

Some potential participants may require more care than can be safely provided through the ALW. **The following conditions automatically render an individual ineligible for the project:**

- (a) Active communicable tuberculosis;
- (b) Bi-Pap dependency without the ability to self-administer at all times [Bi-Pap defined as Bilevel Positive Airways Pressure];
- (c) Chemotherapy;
- (d) Coma;
- (e) Continuous IV/TPN therapy (TPN, or Total Parental Nutrition, is an intravenous form of complete nutritional sustenance);
- (f) Nasogastric tubes;
- (g) Wound Vac therapy (a system that uses controlled negative pressure, vacuum therapy, to help promote wound healing);
- (h) Restraints except as permitted by the licensing agency;
- (i) Stage 3 or 4 pressure ulcers; and
- (j) Ventilator dependency.

D. Who Can Provide ALW Services?

(1) Requirements for ALW Service Providers

Medi-Cal contracts with Residential Care Facilities for the Elderly (RCFEs) and Care Coordination Agencies to provide services to ALW residents. Other providers of waiver benefits may contract directly with Medi-Cal or they may choose to submit invoices through the beneficiary's Care Coordinator.

All service providers are required to meet minimum standards in order to participate in the ALW. Provider qualifications are verified during the application process and on the provider's anniversary date.

(2) Requirements for RCFEs

All RCFEs participating in the ALW must:

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- (a) Be able to provide the AL Waiver benefit as described above and meet the care needs of all participants by delivering all services at all tiers of care.
- (b) Be able to care for cognitively impaired residents.
- (c) Be able to meet the daily needs of non-English speaking residents.
- (d) Meet the licensure and certification requirements for RCFEs set forth by the California Department of Social Services Community Care Licensing Division (CDSS/CCL).
- (e) Be in substantial compliance with licensing regulations and in good standing with the licensing agency. Facilities that are on probation and/or have pending accusations against the licensee are not in substantial compliance for the purpose of the Assisted Living Waiver.
- (f) Enroll as a Medi-Cal Assisted Living Waiver provider.
- (g) Have the following physical plant features:
 - (i) Units must be single occupancy with bathrooms shared by no more than one other resident. Units may be shared at the **documented** choice of the resident.
 - (ii) Units must have kitchenettes (defined as a small refrigerator, a cooking appliance which may be a microwave and storage space for utensils and supplies). The kitchenette requirement is waived for facilities with six or fewer residents (licensed for less than seven beds) if residents have continuous access to the facility's kitchen.
 - (iii) Facilities must have adequate common space to serve meals and conduct activities.
 - (iv) Facilities must have a safe and locked place for the storage of medications.
- (h) Have awake staff on-site 24 hours a day. Facilities with six or fewer residents (licensed for less than seven beds) are required to have staff on site 24 hours per day, seven days per week, but the staff is not required to be awake 24 hours per day.
- (i) Have a hospice waiver.
- (k) Have an emergency response system that enables residents to secure immediate assistance from caregivers. The system must operate in residents' units and in the facility's common space. The response system may be either voice-to-voice or pager-based.

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- (l) Have a **mandatory** ALW guidelines in-service training program for staff and document staff attendance at all training programs;
- (m) Have a process for soliciting and/or obtaining feedback from residents regarding their satisfaction with services;
- (n) Have a quality assurance program to track resident complaints and special incident reports (SIRs), including reports of abuse, neglect and medication errors;
- (o) Have a contingency plan to deliver services in the event of a disaster or emergency;
- (p) Maintain a service record for each resident. Records, at a minimum, must include a care plan, signed by the resident and progress notes. Facilities agree to make those records available to DHCS for audit;
- (q) Agree to collect data as specified.

3. COVERED SERVICES

A. Introduction

This chapter describes the services covered under the California Assisted Living Waiver (ALW).

B. Description of ALW Benefits

ALW waiver benefits for participants residing in an RCFE include:

- Care coordination;
- Nursing Facility (NF) Transition Care Coordination services
- Environmental Accessibility Adaptations

(1) Care Coordination

Every ALW enrollee has a Care Coordinator, who is responsible for identifying, organizing, coordinating, and monitoring services needed by the recipient. The Care Coordinator assists waiver recipients in gaining access to waiver services, state plan services and other community resources. Services provided or coordinated by Care Coordinators include:

- (a) Enrolling residents and verify Medi-Cal eligibility;
- (b) Conducting assessments using the ALW Assessment Tool every six months, or more frequently as indicated by a change in the condition of the resident;
- (c) Determining each resident's level of care (i.e. tier);
- (d) Assist with the development, implementation, and modification of the resident's Individualized Service Plans (ISPs) using the approved ALW ISP form;
- (e) Arranging for Waiver, state plan and other services as determined necessary by the most current resident assessment;
- (f) Monitoring service delivery;
- (g) Helping transition residents from nursing facilities to RCFEs or public housing sites;
- (h) Maintaining progress notes and case records for each enrolled resident;

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- (i) Adhering to the prescribed schedule of resident contact;
- (j) Receiving complaints from residents, families or friends and forwarding complaints using the approved Special Incident Report form to the DHCS;
- (k) Reporting all signs of abuse or neglect to the Ombudsman or APS using the approved Special Incident Report form ; and
- (l) Arranging for payment for vendors who opt not to bill Medi-Cal directly.

(2) Assisted Living Services [including Homemaker, Home Health Aide and Personal Care]

Services provided or coordinated by RCFE staff for ALW residents include:

- (a) 24-hour awake staff to provide oversight and meet the scheduled and unscheduled needs of residents. [This provision is waived in a 6-bed facility];
- (b) Provision and oversight of personal and supportive services including assistance with the residents activities of daily living (ADLs) and instrumental activities of daily living (IADL) to meet both the scheduled and unscheduled needs of the residents;
- (c) Providing assistance with the self-administration of medications or, as necessary, having licensed nursing staff available to administer medications. This does not include 24-hour skilled nursing care or continuous skilled nursing supervision;
- (d) Providing three meals per day plus snacks. Food must meet minimum daily nutritional requirements and special diet needs must be accommodated;
- (e) Providing daily social and recreational activities;
- (f) Developing a care plan for each resident detailing, at a minimum, the frequency and timing of assistance. Residents must be a part of the development process and must sign the care plan.
- (g) Washing, drying and folding all laundry;
- (h) Performing all necessary housekeeping tasks;
- (i) Maintaining the facility;
- (j) Providing intermittent skilled nursing services as required by residents;
- (k) Providing or coordinating transportation as needed to medically necessary appointments and other transportation as identified on the ISP;
- (l) Providing an emergency response system that enables waiver beneficiaries to summon immediate assistance from personal care providers.
- (m) Provide a private or semi-private full bathroom [can not be shared by more than two residents]
and
- (n) Provide a shared common space like a dining room or common activity center that may also be used as a dining room.

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RCFE staff may arrange for other service providers to meet unique or special needs of the resident, but the care provided by these other entities supplements the services provided by the primary service provider and does not supplant it. Examples of such services include physical therapy, speech therapy, and occupational therapy.

(3) Nursing Facility (NF) Transition Care Coordination Services

The Community Transition benefit provides one-time only access to a pool of funds that may be used to help residents of a nursing facility establish a residence in the community (i.e. in a RCFE). The following are examples of expenses that may be reimbursed through this benefit:

- (a) Costs associated with furnishing a residence. Items essential to furnishing a residence are those necessary for a resident to establish his or her basic living arrangement such as a bed, a table, chairs, window blinds, eating utensils, and food preparation items. Items not considered essential include recreational items such as televisions, cable TV, VCRs, stereos, etc. This benefit will not cover items that RCFEs are required by regulation to provide for residents. This benefit may also be used to purchase clothing or personal items such as a tooth brush, comb, etc.
 - 1)
- (b) The expense of telephone set-up fees (if any). Admission/community fees may not be charged to residents enrolled in the ALW.

This benefit is only available to residents transitioning from skilled nursing facilities into the ALW and the benefit is only available once, during the Assisted Living Waiver intake process. Community Transition Funds cannot be used to pay rent.

(4) Medi-Cal State Plan Services

ALW participants are entitled to use all Medi-Cal state plan benefits including all primary, preventive, specialty, acute care and pharmaceutical services. Participants are not expected to use in-home supportive services as these services are being provided through the Assisted Living Services by RCFEs.

Participants requiring short-term placement in a skilled nursing facility to recuperate from an acute episode will return to their primary residence (i.e. RCFE) and continue enrollment in the ALW. Participants requiring long-term placement in a skilled nursing facility will be terminated from the project.

(5) Other Community Resources

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Care Coordinators are expected to refer ALW enrollees to or arrange for enrollees to participate in services funded through the Older Americans Act or other reimbursement sources as determined to be necessary by the ALW Assessment. Examples of appropriate services might include legal services, money management services, or friendly visiting.

C. Program Requirements

(1) Resident Privacy

- (a) ALW benefits are furnished to residents who reside in private residency units. While all waiver residents must be offered a private unit, residents may ask to share a residence with a roommate of their choice.
 - (i) Sharing a residence may not be a requirement of program participation.
 - (ii) The ISP must reflect the choice of the resident to share a residence.
 - (iii) Residents who wish to share a residence must initiate and submit their request to their Care Coordinator who will forward the request to the housing provider. If the resident is cognitively impaired, the request may be initiated and submitted to the Care Coordinator by the resident's responsible party.
- (b) All residences shall have kitchenettes and private or semi-private bathrooms not shared by more than one other resident.
- (c) All ALW residents have a right to privacy. Residences may be locked at the discretion of the resident, except when a physician or mental health professional has certified in writing that the resident is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with the fire code.)

(2) Resident-Directed Care

The Assisted Living benefit was designed to be a resident-directed service. Persons with cognitive disabilities will direct their own care to the best of their ability. Residents who are not able to direct the development of their own care and participate in the oversight of their own services may be assisted by a family member or other responsible party, such as a legal conservator. The person(s) responsible for the resident's health care decisions may assume a lead role in ISP or care plan development and oversight in collaboration with the provider and the Care Coordinator as necessary.

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D. Exclusions

Payment made by Medi-Cal for Assisted Living Services cannot be used to pay for rent, the purchase of food, or the cost of furnishing units with kitchenettes. Rent and food are paid for by the resident. The RCFE is responsible for furnishing the kitchenette.

The room and board costs charged by a RCFE to a SSI recipient cannot exceed the amount of the SSI check **MINUS** the Personal Needs Allowance.

E. Leave of Absence and Discharge

(1) Introduction

AL Waiver recipients must reside in a setting served by an ALW Primary Service Provider in order to receive AL Waiver services. A recipient that is not a resident of either an AL waiver contracted RCFE or a publicly-subsidized housing setting served by a contracted Home Health Agency cannot receive AL Waiver services even if all other eligibility criteria are met.

(2) Leave of Absence

If ALW recipients are absent from their primary residence (e.g. RCFE) for more than 24 hours for health or personal reasons, AL Waiver Services are not being provided and may not be billed.

(3) Discharge From a RCFE

If a RCFE initiates discharge of an AL Waiver recipient, the discharge must be done in accordance with Community Care Licensing requirements and in cooperation with the resident's Care Coordinator.

(4) Move to Another ALW Setting

If a recipient requests to move or is moved from one AL Waiver setting to another AL Waiver setting, the discharging AL Waiver service provider assists in coordinating the placement, and the recipient remains eligible to receive AL Waiver services in the new setting.

Any time a change in AL Waiver service provider is necessary, the change must be coordinated with the recipient's Care Coordinator.

(5) Move to a Non-ALW Setting

Changes in residence for an AL Waiver recipient must be coordinated with the Care Coordinator. If it appears that a nursing facility or other placement is

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necessary, the facility must coordinate with the Care Coordinator and jointly develop a plan to seek an appropriate placement.

F. Termination of Assisted Living Waiver Services

(1) Introduction

In most cases, AL Waiver recipients must be given a written 10-day advance notice of termination that includes information on their right to request a fair hearing. This notice should not be confused with the 30-day written notice that is required to evict a resident from an RCFE. A resident who is terminated from the ALW can still reside in the RCFE if the resident meets RCFE admission and retention criteria.

(2) Criteria for Denial or Termination of ALW Services

- (a) Enrollment in the ALW may be denied or terminated when any one of the following circumstances occur:
 - (i) The resident elects in writing to terminate services;
 - (ii) The resident elects to receive services through a different Home and Community-Based waiver;
 - (iii) The resident's health care needs no longer meet the level of care necessary to qualify for the ALW program;
 - (iv) The resident's Medi-Cal eligibility and/or aid code changes, such that he or she is no longer eligible to participate in the waiver;
 - (v) The cost of waiver services plus state plan benefits exceeds the cost of care in the alternative nursing facility setting;
 - (vi) The resident is unwilling or unable to comply with his or her Individual Service Plan;
 - (vii) The waiver service provider is unwilling or unable to provide the amount of authorized services as requested by the ISP and/or physician order, and the resident, despite the full assistance of the Care Coordinator and the Department of Health Services, is unable to arrange for another waiver service provider; and/or,
 - (viii) The resident is unable to maintain health, safety, and/or welfare in the assisted living setting as determined by the Care Coordinator in conjunction with the resident, the RCFE, the resident's family, the resident's physician, and/or others as appropriate.
- (b) When waiver services are denied, reduced or terminated, a notice of action will be forwarded to the resident by the Medi-Cal Operations Division (MCOD) of DHCS in conformance with Title 22, 50952 and 51014.1.
- (c) Procedures for terminating services

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In the event that a provider is no longer capable of meeting the needs of an ALW resident, the Care Coordinator in conjunction with DHCS, assists in the emergency relocation of the resident and/or in securing another provider to meet the resident's needs. In such a case, RCFEs must also comply with all CDSS/CCL licensing requirements associated with the discharge and transfer of the resident.

ALW providers may not discharge a resident simply because the resident requires care at a higher service tier. Providers are expected to serve residents at all service levels unless they exceed the admission/retention criteria outlined in Chapter 5, Section A. Providers must receive the approval of an ALW resident's Care Coordinator and DHCS before initiating any termination or discharge procedures.

If an ALW resident voluntarily chooses to no longer participate in the ALW, the resident should contact his/her Care Coordinator to initiate the withdrawal process. ALW residents also retain the right to move to another ALW provider setting, although no assurances may be made that services would be available in another location.

(3) Right to a Fair Hearing

Beneficiaries must be given written notice by DHCS at least 10 days prior to action by the Department that denies, reduces or terminates services. Upon receipt of written notice, beneficiaries have the right to appeal the intended action of the Department through the Fair Hearing Process as per Title 22, CCR 51014.01.

4. THE ALW PROCESS

A. Introduction

Care Coordinators are expected to coordinate all of the waiver, state plan and community resources needed to enable a resident to continue living in the community. Services are delivered pursuant to an assessment and the development of a service plan. Service provision is routinely monitored and residents are reassessed every six months.

B. Overview of the ALW Process

The ALW process includes the following activities performed in the order in which they are listed.

- (1) Referral of a potential ALW resident to a Care Coordinator;
- (2) Screening of the applicant to determine whether to conduct an assessment;
- (3) Verification of Medi-Cal eligibility;
- (4) Assessment of the beneficiary using the ALW assessment tool;
- (5) Choosing the ALW;
- (6) Development of an Individual Service Plan (ISP);
- (7) Enrollment of the resident in the ALW;
- (8) Selection by the resident of a participating RCFE;
- (9) Assessment of the resident by the RCFE;
- (10) Development of a Care Plan by the RCFE;
- (11) Transition by the resident to the RCFE (if not already residing in that location);
- (12) Provision, oversight and monitoring of services; and
- (13) Reassessment of the resident.

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C. Referral of Potential ALW Residents

In each county in which the ALW is implemented, Care Coordinators engage in outreach and case finding activities to inform the community of the existence of the program and establish working relationships with potential sources of referral. These referral sources may include:

- Discharge planners in acute care hospitals;
- Discharge planners in long-term care facilities;
- County-based In-Home Supportive Services (IHSS) programs;
- Medi-Cal Field Office staff;
- Home health agencies, social service agencies, physicians and other home health a community providers; and
- Potential residents and their families.

The referral of potential residents to the ALW may be initiated by contacting a participating Care Coordination Agency. A list of all ALW Care Coordination Agencies may be found on the California Department of Health Care Services (DHCS) website

(<http://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx>)

D. Screening Prior to Assessment

When individuals are referred to Care Coordinators, a screening process is used to identify potential applicants who clearly do not require a nursing facility (NF) level of care or who clearly require more care than is allowed in the ALW (e.g., if individuals have no ADL deficiencies or have a condition listed in Chapter 2, Section C4, that automatically renders them ineligible for the project).

If it is determined via the screening process that a potential participant does not meet the ALW admission criteria, a full assessment would not be conducted.

The screening process does **NOT** determine a potential resident's level of care. The determination of a resident's level of care can only be made when a Care Coordinator administers and scores the ALW Assessment Tool.

E. Verification of Medi-Cal Eligibility

The Care Coordinator verifies a potential resident's Medi-Cal eligibility by referring to one or more of the following sources of information:

- Medi-Cal Eligibility Data System (MEDS) screen print;

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- Certification from the Claims and Real Time Eligibility System (CERTS) or the Automated Eligibility Verification System (AVES). Both of these systems are available to Medi-Cal Providers through the Medi-Cal Fiscal Intermediary, ACS-Xerox; and/or
- A county-issued immediate need Medi-Cal card.

Applicants who appear eligible for Medi-Cal, but are not receiving benefits are referred by the Care Coordinator to their county social service office for Medi-Cal eligibility determination. Individuals already receiving SSI/SSP payments are automatically eligible for Medi-Cal as arranged by the local Social Security Administration office.

Individuals who have not applied for Medi-Cal must complete (or have a designated representative complete) and submit a Medi-Cal application to their local county social service office (at <http://www.dhcs.ca.gov/provgovpart/county>). More information about Medi-Cal, including answers to frequently asked questions, is at DHCS website: <http://www.dhcs.ca.gov/services/medi-cal>

Once the applicant has been enrolled in the Medi-Cal program, Care Coordinators may proceed with the enrollment process.

Care Coordination agencies are responsible for verifying resident eligibility by the first of each month.

F. The Assessment Process

(1) Purpose

Once a resident's Medi-Cal eligibility has been established, the Care Coordinator conducts an assessment to determine the resident's level of care and capacity to live independently. The assessment also determines the services that are needed for the applicant to safely sustain residence in the community with as much independence as possible. Assessment precedes enrollment in the ALW; until the applicant is assessed and a care plan is developed, s/he cannot be enrolled in the ALW.

(2) The Assessment Process

The assessment process requires a **face-to-face interview** with the Care Coordinator and the resident and, as appropriate, contact with the family, legal representatives and/or other informal supports. Residents and family are expected to remain involved in the assessment and service planning process.

The ALW Assessment Tool is used to conduct the assessment, with points assigned based on the applicant's response to specific questions. The total number of points assigned determines the applicant's level of care.

G. Service Level (“Tier”) Determination

(1) Overview

The primary AL waiver benefit is delivered to residents in one of four possible “tiers” of service intensity as determined by the ALW Assessment Tool. Payment rates for the assisted living services and assisted care are based on each resident’s current service level (see Appendix III).

(2) Description of Service Tiers

Tier one applies to residents with the lowest level of support need; tiers two and three apply to residents with more significant support needs, respectively. Tier four services are provided to residents with the most intense support needs who are eligible for the ALW.

(3) Reassessment Schedule

The Care Coordinator is responsible for reassessing each resident every six months or upon significant changes in condition. The level of service (i.e. tier) is also reevaluated, and modified as needed, at this time.

H. Choosing the ALW

Once the applicant has been determined to need a NF level of care, the Care Coordinator is required to provide the prospective resident with information about nursing home care and community-based alternatives to NF care. Care Coordinators must tell applicants that they have the right to choose residence in a nursing facility, apply for services from another waiver program, or enroll in the ALW.

Care Coordinators must also provide the consumer with copies of the Freedom of Choice Letter and the Freedom of Choice Document. The consumer must sign the Freedom of Choice Document, which verifies that information about community-based alternatives to nursing homes has been provided and the consumer has chosen to participate in the ALW.

I. Developing an Individual Service Plan (ISP)

(1) Purpose

Once residents have documented their choice to participate in the ALW, the Care Coordinator develops a plan that addresses identified needs, outcomes to be

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achieved, and services to be provided in support of goal achievement. This plan provides a focus for the needs identified in the assessment; organizes the delivery system for the resident; and helps assure that the services being delivered are appropriate to the resident's needs.

(2) Format

The result of this process is the development of an Individual Service Plan (ISP) that:

- Identifies the resident's needs;
- Specifies the intervention or service that will be provided to address each need;
- States the goal and anticipated outcome of each intervention;
- Identifies the name and phone number of each provider of service;
- States the date each service is expected to begin and end (if the service will be time-limited instead of ongoing);
- Specifies the funding source for the service if it is not a waiver benefit (e.g. a service may be paid for by Medi-Cal state funds or provided without charge by a community-based non-profit organization);
- Documents any disagreement the resident has with any part of the plan, along with the resolution of the disagreement; and
- Lists all participants of the ISP team.

The ISP is operative until six months after the date of the assessment or until the resident experiences significant changes in his/her condition. Copies of the ISP are provided to the resident, the resident's family or guardian, as appropriate, and to the RCFE providing the assisted living services.

J. Enrollment of the Resident

(1) Approved and Pending Status

A resident is in 'Approved and Pending' status when the Care Coordinator submits to DHCS the name of the enrollee, the enrollee's completed, signed and scored Assessment Form, the resident's completed and signed ISP, and the Medi-Cal Verification Form.

(2) Verification of Approved and Pending Status

DHCS will review the submitted documentation. Upon approval, DSHS will notify the Care Coordinator that the resident is approved and pending placement.

(3) Enrollment of the Resident

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The resident will be enrolled into the ALW when he/she is placed into the assisted living setting. Residents who are current residents of ALW – participating RCFEs are enrolled into the ALW the day that they are approved. All residents must be enrolled in the Assisted Living Waiver prior to billing by either the Care Coordinator or the RCFE provider.

K. Transitioning to a RCFE

(1) Selection of a RCFE

The Care Coordinator is responsible for assisting ALW residents in selecting RCFEs to which they will move (or continue to reside). Family members, friends and/or legal representatives should be encouraged to visit identified facilities with residents to assist in the selection process.

(2) Acceptance by the RCFE

RCFEs are not required to accept every ALW resident who selects their facility, although all ALW service providers are required to serve residents at all service tiers. Facilities may choose to not accept residents who have needs that would likely not be best served in that location (e.g. a resident who has a history of wandering in a facility located on a busy street with fast-moving traffic).

(3) Residents Who Move From a Nursing Home

Residents who move from a nursing facility may access funds from a Community Transition benefit to aid, as needed, in their transition to the community (see Chapter 3 Section B3 for a full description of the use of these funds). Care Coordinators are responsible for arranging the services or purchasing the items that are reimbursed from this fund.

L. Site-Specific Service Plans

(1) Purpose

RCFEs participating in the ALW are responsible for developing an individualized care plan for each resident that provides detailed information about the services that will be provided by the RCFE. The care plan is used by the RCFE's staff to provide services that are individualized to each resident and are in accordance with the ISP developed by the Care Coordinator.

(2) Process

The care plan developed by the RCFE will be based on the assessment conducted by the facility and on the ISP developed by the Care Coordinator for

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the resident. While the ISP provides general information about the services that will be provided for the resident, the care plan developed by the RCFE will provide more detailed information about the services that will be provided (specifying at a minimum the frequency and timing of assistance to be provided).

For example, the ISP developed by the Care Coordinator might state that the service provider will assist the resident with showers. The care plan developed by the RCFE would provide additional details about the provision of this service (e.g. staff will provide assistance with showers on Monday, Wednesday and Friday at 6:30 a.m., helping the resident into the shower providing any assistive devices and providing stand-by assistance while he/she showers).

Following are general guidelines for the development of care plans:

- Services should be planned and delivered in a manner that meets residents' needs and preferences;
- Residents have the right to participate in the development of their care plans to the full extent of their ability;
- **Care plans must be signed by the participant.** A copy of a signed care plan must be retained in the resident's file
- Care plans must be developed within no more than one week after an ALW resident moves to an RCFE; and
- Care plans developed for ALW residents must meet all applicable licensing/regulatory requirements for RCFEs.

M. Service Delivery

(1) The Role of the Care Coordinator

Care Coordinators are responsible for arranging for the provision of all needed services as identified on the resident's ISP. This includes all waiver benefits, all Medi-Cal state plan services and all services provided by community resources.

(2) The Role of the RCFE

RCFEs are responsible for providing services as indicated on the ISP developed by the Care Coordinator and on the facility-specific care plan. As needed, the provision of these services should be coordinated with services provided by other service providers arranged by the Care Coordinator.

Because the ALW is designed to provide a higher level of care than would otherwise be allowed in RCFEs, participating providers must adhere to ALW-specific requirements that apply to the provision of skilled nursing care. These requirements, as outlined in the following chapter, were developed to protect the health and safety of ALW residents.

N. Monitoring Service Delivery

(1) Purpose

The Care Coordinator is responsible for monitoring the delivery of services for ALW residents. This is accomplished through contact with the resident to determine if the services provided are meeting the resident's needs and whether the resident is satisfied with the provision of services.

(2) Schedule for Contact with Residents

Care Coordinators are required to have contact with ALW residents according to the following schedule, at a minimum:

- ✓ Telephone contact every 30 days
- ✓ Face-to-face visit every 90 days
- ✓ Assessment visit every 6 months

(3) Incidents and Concerns

RCFEs participating in the ALW are expected to comply with all reporting requirements mandated by licensing regulations (e.g. for incidents, suspected abuse, etc.). Participating RCFEs must also forward to residents' Care Coordinators any special incident reports (SIRs) that have been submitted to the licensing agency. In addition, RCFEs must report to Care Coordinators any concerns expressed by a resident, the resident's family and/or others that indicate the resident may be at risk. Such concerns must be reported to the Care Coordinator within 24 hours of receipt, and must be documented in the resident's record. Use the standard two (2) page SIR form **LIC 624 (4/99)**. A copy is located in Appendix IV of this Manual. Copies can be made and originals can be downloaded from the California Department of Social Services web site; <http://www.dss.cahwnet.gov/cdssweb>

(4) Signs of Abuse or Neglect

If a resident exhibits any sign of abuse or neglect, the RCFE should follow all licensing requirements for reporting the suspected abuse or neglect. The service provider is also required to notify the resident's Care Coordinator. Reports must be documented in the resident's record. Use the standard two (2) page SIR form **LIC 624 (4/99)**. A copy is located in Appendix IV of this Manual. Copies can be made and originals can be downloaded from the California Department of Social Services web site; <http://www.dss.cahwnet.gov/cdssweb>

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O. Reassessment

(1) Timeline

Reassessments are performed by the Care Coordinator every 6 months, or when the resident experiences a significant change in condition.

(2) Process

When reassessing a resident, Care Coordinators conduct another complete assessment using the ALW assessment tool. In addition, a new ISP is developed and the updated level of care recorded on the new ISP. The updated Assessment and ISP are faxed by the Care Coordinator to DHCS.

5. PROVISION FOR SKILLED NURSING NEEDS

A. Prohibited Health Conditions

Some individuals who are at a nursing facility level of care may not be served in the ALW because their conditions and care needs are beyond the scope of the assisted living benefit. These prohibited health conditions include:

- (a) Active communicable tuberculosis;
- (b) Bi-Pap dependency without the ability to self-administer at all times;
- (c) Chemotherapy;
- (d) Coma;
- (e) Continuous IV/TPN therapy (TPN, or Total Parental Nutrition, is an intravenous form of complete nutritional sustenance);
- (f) Nasogastric tubes;
- (g) Wound Vac therapy (a system that uses controlled negative pressure, vacuum therapy, to help promote wound healing);
- (h) Restraints except as permitted by the licensing agency;
- (i) Stage 3 or 4 pressure ulcers; and
- (j) Ventilator dependency.

Individuals who have any of these conditions will not be accepted for enrollment in the ALW. If an ALW resident develops one or more of these conditions, the service provider should contact the resident's Care Coordinator to arrange for transfer to a more appropriate level of care.

(1) Temporary Conditions

If a waiver resident develops a prohibited health condition that is thought to be temporary, the resident may be transferred to a higher level of care until the condition has been managed. The RCFE site should coordinate the transfer with the Care Coordinator, and may not bill Medi-Cal for the days that the resident is away from the residence.

(2) Permanent Conditions

If a resident develops a prohibited health condition that is determined to be permanent in nature, the resident is no longer appropriate for the ALW and the RCFE should contact the resident's Care Coordinator to facilitate a transfer to another setting.

B. Conditions That Require a Waiver from RCFE Regulations

(1) Purpose

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In order to serve residents at a nursing facility level of care, specified RCFE regulations have been waived for ALW residents. That is, RCFEs participating in the ALW may admit or retain ALW residents with specified conditions that are otherwise prohibited in RCFEs or normally require an exception from CDSS (the need for the exception is waived for ALW residents).

(2) Staffing Requirements

Under these waivers, direct care staff may perform specified tasks; while other tasks may be performed only by an appropriately skilled professional (see Appendix I for a breakdown of these responsibilities). These waivers also assume that the training requirements outlined at the end of this section are followed for all waived health conditions.

Staffing guidelines are also provided for conditions that do not require a regulatory waiver (see Appendix II).

(3) Waived Conditions

Under the waivers that have been granted for the ALW, participating RCFEs may admit or retain residents who:

- (a) Require 24-hour skilled nursing or intermediate care [a waiver of Health and Safety Code Section 1569.72(a)(1) and Title 22, CCR, 87582(c)(2)];
- (b) Are indefinitely bedridden, subject to an approved bedridden fire clearance (a waiver of Health and Safety Code 1469.72);
- (c) Require gastrostomy care for a healed, stable, gastrostomy as determined and documented by the resident's physician [a waiver of Title 22, CCR, 87701(a)(2)];
- (d) Are dependent in all ADLs [a waiver of Title 22, CCR, 87701(a)(5)];
- (e) Have a healed, stable tracheostomy, as determined and documented by the resident's physician [a waiver of Title 22, CCR, 87701(a)(6)];

C. Conditions That Do Not Require a Waiver

Conditions that are allowed under the current RCFE regulations, with specified care performed either by residents themselves or by appropriately skilled professionals, are also allowable in the ALW. Trained direct care staff may assist residents with self-performance/self-administration of these specified tasks.

(1) Staffing Requirements

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To provide clarity for ALW providers as to what tasks may be performed by trained direct care staff and what tasks must be performed by an appropriately skilled professional, guidelines have been developed. These guidelines may be found in Appendix II.

(2) Applicable Conditions

Under these guidelines, RCFEs may admit and retain residents:

- (a) Who require supplemental gas or liquid oxygen, as specified in Title 22, CCR, 87703 (As specified in 87703(c)(1), the licensee must obtain prior approval from the licensing agency to accept or retain a resident who requires the use of liquid oxygen);
- (b) With an indwelling (Foley) catheter, as specified in Title 22, CCR, 87707;
- (c) Who require Intermittent Positive Pressure Breathing (IPPB) treatments, as specified in Title 22, CCR, 87704;
- (d) With either a colostomy or ileostomy, as specified in Title 22, CCR, 87705;
- (e) With contractures, as specified in Title 22, CCR, 87709;
- (f) With diabetes, if the resident is able to perform his/her own glucose testing and is able to administer his/her own medication (orally or through injection) or has it administered by an appropriately skilled professional, as specified in Title 22, CCR, 87710;
- (g) Who require enemas and/or suppositories, as specified in Title 22, CCR, 87706;
- (h) With incontinence of bowel and/or bladder, as specified in Title 22, CCR, 87708;
- (i) Who require intramuscular, subcutaneous or intradermal injections, if the injections are administered by the resident or by an appropriately skilled professional, as specified in Title 22, CCR, 87711;
- (j) With Stage 1 or Stage 2 pressure sores (dermal ulcers), if the condition has been diagnosed by an appropriately skilled professional, as specified in Title 22, CCR, 87713; and

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- (k) Who require wound care, as specified in Title 22, CCR.

D. Training Requirements

To ensure that direct care staff are capable of assisting with procedures for all allowed health conditions, the **following training and documentation requirements apply to all of the conditions listed in sections (B) and (C) of this chapter.**

- (a) Direct care staff must demonstrate the ability and skills to assist residents with the specified health-related task;
- (b) Direct care staff must follow the direction and supervision of the licensed nursing staff and other appropriately skilled professionals who provide the training, with the training to include hands-on instruction in both general and resident-specific procedures;
- (c) Only appropriately skilled professional staff may train direct care staff; it is not acceptable for one direct care staff member to train another direct care staff member unless the staff person providing the training is an appropriately skilled professional;
- (d) Trained staff must be provided with instructions as to the appropriate response(s) in case of an emergency while assisting a resident, with these procedures resident-specific and documented on the resident's facility-specific service plan;
- (e) Training must be completed prior to direct care staff providing services to the resident;
- (f) Documentation of the training must be maintained in the personnel file of each staff member providing services to the resident, including the date the training occurred, the name and telephone of the appropriately skilled professional providing the training, and an outline of the instructions for the procedures for which training was provided;
- (g) An appropriately skilled professional should review staff performances as necessary, and at least bi-annually;
- (h) If the condition of the resident changes, all direct care staff providing care to that resident must complete any additional training needed to meet the resident's new needs, as determined by the resident's physician or a licensed

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professional designated by the physician. This training must be provided by an appropriately skilled professional.

- (i) Any change in the resident's condition should be documented and reported promptly to the resident's physician and Care Coordinator.

E. Documentation

All care provided by an appropriately skilled professional, including skilled nursing care provided by licensed nursing staff must be documented in the resident's file. These records must be made available for inspection by DHCS and CDSS upon verbal or written request.

6. RECORDS AND DATA COLLECTION

A. Documentation

ALW service providers must document in resident files as required by applicable licensing agencies. In addition, RCFEs must document any excessive refusals of service by ALW residents.

A resident's file must contain the following documents:

1. RCFE Assessment;
2. RCFE Service Plan;
3. Incident Reports, if applicable; and
4. Documented refusal of Service, if applicable.

Care Coordinators are required to provide RCFEs with the following documents:

1. Completed Assessment Tools; and
2. Completed and signed ISPs.

B. Confidentiality

The names of persons receiving services through the ALW are confidential and are protected from unauthorized disclosure. All resident-related information, records, and data elements must be protected by the service providers from unauthorized disclosure.

C. Data Collection

As the AL Waiver program is a federally funded program, DHCS is responsible for preparing and submitting an evaluation of the project to the State Legislature. The Legislature will then determine whether to continue and/or expand the project. Data is essential to the development of the report.

Therefore, ALW service providers may be requested to submit data regarding participating residents to DHCS. It is essential that any data submitted be accurate and complete and be submitted within the specified time frame.

D. Storage of Records

Each participating RCFE is responsible to maintain and store all information obtained on each ALW resident for a minimum of three years.

7. QUALITY ASSURANCE

A. Quality Assurance Plans

Participating RCFEs are required to develop and maintain quality assurance plans to track the following issues:

- ✓ Resident complaints;
- ✓ Incident reports, including abuse, neglect and medication errors;
- ✓ Required staff training; and
- ✓ Contingency plan(s) to provide services in case of a disaster or emergency where the scheduled staff is not available.

RCFEs must also meet all regulatory requirements for all of these issues.

B. Opportunities for Resident Feedback

Participating RCFEs are also required to provide residents with opportunities to offer feedback regarding their level of satisfaction with services. Examples of such opportunities include:

- ✓ Suggestions boxes;
- ✓ Satisfaction surveys; and
- ✓ Resident council meetings.

C. ALW-Wide Quality Assurance Measures

As part of an overall quality assurance plan, DHCS will conduct annual audits of ALW service records, including the provider's care plans and progress notes.

DHCS will also conduct Participant Experience Surveys to obtain feedback from participants about their experience in the waiver program.

8. BILLING AND REIMBURSEMENT

A. Overview

Participating RCFEs submit monthly billings to DHCS for services provided to ALW residents. Room and board payments (for rent and the cost of food) are paid directly to the RCFE by residents (see Section D below for more information on room and board payments).

B. Service payments

(1) Overview

ALW provider's bill DHCS directly for services provided, using the **UB-04** billing form (formerly UB-92). Treatment Authorization Requests (TARs) are **NOT** required. Only providers enrolled in the Medi-Cal system can successfully submit claims for services, and providers may only bill for residents who are enrolled in the ALW.

RCFEs use four codes for billing, which correspond to the four service tiers. Each tier is paid at a different payment rate (see Appendix III for the current rate schedule).

(2) The Billing Process

- (a) Each provider must submit a billing statement that specifies the service provided, the procedure code for the service, the dates of service, the number of units of service provided (i.e. the number of days services were provided), the rate per unit, and the total charge.
- (b) The billing statement must also specify the tier of service provided as determined by the most recently completed assessment and recorded on the most recently completed ISP.
- (c) Invoices are submitted to the Fiscal Intermediary, ACS-Xerox. Providers should bill at the end of each month for services provided during that month.

C. Billable Days for AL Waiver Services

Reimbursement will be made only for days the resident is eligible for and is receiving services in the facility. Reimbursement will not be made when the recipient is absent for 24 hours or more. In such cases, reimbursement will be made for the day the resident returns, but not for the day the resident leaves.

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D. Room and Board Payments

(1) Overview

Medi-Cal does not pay for Room and Board expenses. Each resident is financially responsible for his/her own Room and Board and should be contacted directly for payment by the RCFE. Residents may pay for Room and Board with funds they receive from any of several sources such as Social Security benefits, Supplemental Security Income (SSI), State Supplemental Payment (SSP), or other personal income sources.

(2) Room and Board Payments

The room and board costs charged by a RCFE to a SSI recipient cannot exceed the amount of the SSI check **MINUS** the Personal Needs Allowance. This amount may be calculated as follows:

- (a) The current (2009) amount of SSI/SSP payments is \$1007 per month;
NEED TO GET CURRENT AMOUNT
- (b) The amount designated for the Personal Needs and Incidentals Allowance (PNIA) is currently \$117 per month;
- (c) Room and board payments for SSI residents may not exceed the difference between SSI/SSP payments and the PNIA (\$1007 - \$117 = \$890).

E. Completing the UB-04 form

(1) Overview

ALW providers will bill DHCS directly using the **UB-04** billing form. A Treatment Authorization Request (TAR) is **NOT** required.

Only providers enrolled in the Medi-Cal system can successfully submit claims for service and providers may only bill for residents already enrolled in the ALW.

(2) Process

- (a) You must submit a **UB-04** form for each participant. Complete the following fields on the form. Leave the other fields **blank**.

Field 1 Enter your organization name and address, including ZIP Code

Field 3 Although this is an optional field, creating a participant control number will help you identify a participant should you ever need to follow up with a concern regarding your **UB-04**. Your offices

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- participant record number is a common choice for this field.
- Field 4 Enter the number "133."
- Field 12 Enter the participant's last name followed by the first name
- Field 13 Enter the participant's address including ZIP code
- Field 14 Enter the participant's birth date starting with the month (2digits), date (2 digits) and year (4 digits).
- Field 42 Enter the code "001" on the last detail line (line #23) to designate the total charge line.
- Field 43 Enter "Total Charges" in the white box at the bottom of the field.
- Field 44 Enter the HCPCS code on the red line (line #2). The codes are:

Tier 1	T2031U1	\$52/ day
Tier 2	T2031U2	\$62/ day
Tier 3	T2031U3	\$71/ day
Tier 4	T2031U4	\$82/ day

- Field 45 Enter the service dates in a from/through format. Enter the start date for the month on the white line (line #1) and the end date for the month on the red line (line #2).
- Field 46 Enter the number of units of service provided during the billing period on the red line. The assisted living benefit is 1 unit of service per day.
- Field 47 Enter the charge corresponding to the service provided on the red line (directly across from the end date for service. At the bottom of the column, line 23, enter the total charge for the month.
- Field 50 Enter "O/P Medi-Cal" on line A.
- Field 51 Enter your provider number.
- Field 60 Enter the 14 digit Medi-Cal BIN number
- Field 84 Only use to indicate attachments (rare), or to indicate the patient is over 100 years of age.
- Field 85 Sign and date the form in black ink only.

(b) Invoices are submitted to:

MEDI-CAL
Fiscal Intermediary, ACS-Xerox
P.O. Box 15600
Sacramento, CA 95852-1600

Contacting ACS-Xerox

If you need help completing the **UB-04**, you can call the Provider Support Center at 800-541-5555.

ACS-Xerox also maintains a Small Provider Billing Unit, a free, full-service billing assistance and training program. Claims processors and regional field

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representatives work directly with providers in a structured program to assist in completing and submitting Medi-Cal claims. This detailed training program lasts one year. To qualify, you must submit no more than 100 claim lines per month. To contact this unit, call: (800) 541-555 ext 1275.

9. APPENDIX I – STAFFING REQUIREMENTS FOR WAIVED HEALTH CONDITIONS

Waived Condition	Waived Regulations	Direct Care Staff Tasks	Appropriate Skilled Professional Tasks
1) Residents requiring 24-hour skilled nursing or intermediate care.	Title 22, CCR, §87582(c)(2), which states: “No resident shall be accepted or retained if the resident requires 24-hour skilled nursing or intermediate care.”	Trained direct care staff will assist the resident as necessary with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).	Appropriately skilled professional staff (RNs or LVNs) will provide nursing care as necessary to residents to meet their skilled nursing needs.
2) Indefinitely bedridden residents, subject to an approved bedridden fire clearance.	Health and Safety Code §1569.72, which states: “(a) Except as otherwise provided in subdivision (d), no resident shall be admitted or retained in a residential care facility for the elderly if any of the following apply (2) The resident is bedridden, other than for a temporary illness or for recovery from surgery.”	Trained direct care staff will provide pressure relief at least every two hours for any resident who is unable to re-position independently, either in a chair or in bed. Residents may wear safety restraints provided they are able to release the restraints independently.	Appropriately skilled professional staff will provide direct care staff with training on re-positioning the resident at least every two hours if the resident is not self-mobilized, and will ensure that equipment is utilized appropriately.
3) Residents requiring gastrostomy care for a healed, stable, gastrostomy as determined and documented by the resident’s	Title 22, CCR, §87701(a)(2), which prohibits accepting or retaining residents who require gastrostomy care.	Trained direct care staff may assist the resident with routine hygiene and gastrostomy care as follows: <ul style="list-style-type: none"> • Bathe the site - clean around the gastric tube. • Open cans of tube feeding. • Pour tube feeding into a bag. 	Appropriately skilled professional staff (which, in this case, is restricted to licensed nursing staff acting within their scope of practice) will perform any of the following gastrostomy care that the resident is not able to self-perform: <ul style="list-style-type: none"> • Change the settings on the feeding pump.

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Waived Condition	Waived Regulations	Direct Care Staff Tasks	Appropriate Skilled Professional Tasks
physician.		<ul style="list-style-type: none"> Position the pump. May turn the power on or off, but cannot start the pump (feeding). 	<ul style="list-style-type: none"> Connect or disconnect the feeding tube. Start the pump. Change the stoma dressing. Replace the tube as per the Individual Service Plan (ISP).

Waived Condition	Waived Regulations	Direct Care Staff Tasks	Appropriate Skilled Professional Tasks
4) Residents dependent in all ADLs.	Title 22, CCR, §87701(a)(5), which prohibits accepting or retaining residents who are dependent in all ADLs as set forth in §87584.	Trained direct care staff may assist residents with all ADLs as necessary.	Appropriately skilled professional staff will provide training as needed to enable direct care staff to perform ADL care.
5) Residents with a healed, stable tracheostomy, as determined and documented by the resident's physician.	Title 22, CCR, §87701(a)(6), which prohibits accepting or retaining residents with tracheostomies.	<p>Trained direct care staff may assist the resident as necessary to self-perform the following tracheostomy care:</p> <ul style="list-style-type: none"> Set up a suction machine. Turn the power on or off. Hand the catheter to the resident. Clean the tracheostomy appliance. Hand the appliance to the resident. 	<p>Appropriately skilled professional staff (which, in this case, is restricted to licensed nursing staff acting within their scope of practice) will intervene and perform any of the following tracheostomy care that the resident is not able to self-perform:</p> <ul style="list-style-type: none"> Perform suctioning. Remove tracheostomy appliance. Re-insert tracheostomy appliance as per the ISP. Change dressing as necessary.

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Definitions of terms are as follows:

¹Direct care staff: As defined in Title 22, CCR, Section 87101(d), “direct care staff” means: “the licensee, and/or those individuals employed by the licensee, who provide direct care to the residents, including, but not limited to, assistance with activities of daily living.”

²Appropriately Skilled Professional: As defined in Title 22, CCR, Section 87101(a), “appropriately skilled professional” means: “an individual that has training and is licensed to perform the necessary medical procedures prescribed by a physician. This includes but is not limited to the following: Registered Nurse (RN), Licensed Vocational Nurse (LVN), Physical Therapist (PT), Occupational Therapist (OT) and Respiratory Therapist (RT). These professionals may include, but are not limited to, those persons employed by a home health agency, the resident, or facilities and who are currently licensed in California.”

10. APPENDIX II – STAFFING REQUIREMENTS FOR OTHER CONDITIONS

Condition	Regulatory Reference	Direct Care Staff Tasks ¹	Appropriately Skilled Professional Tasks ²
1) Residents requiring supplemental gas or liquid oxygen.	Title 22, CCR, §87703. (<u>Note</u> : The licensee must obtain prior approval from the licensing agency to accept or retain a resident who requires the use of liquid oxygen, as specified in Section 87703(c)(1)).	<p>Trained direct care staff may assist with the self-administration of oxygen as follows:</p> <ul style="list-style-type: none"> • Re-position a nasal cannula or mask. • Move the oxygen tank, or oxygen concentrator, as necessary. • Read directions to the resident. • Turn the power to a concentrator on or off. • Verify that the flow rate is consistent with the ISP. 	<p>Appropriately skilled professional staff will perform the following tasks if the resident is not able to self-perform:</p> <ul style="list-style-type: none"> • Set up or change the oxygen delivery system. • Adjust flow rates or method of delivery.
2) Residents with an indwelling (Foley) catheter	T Title 22, CCR, §87707.	<p>Trained direct care staff may assist residents with catheter care as follows:</p> <ul style="list-style-type: none"> • Perform routine hygiene care, including bathing/cleaning the catheter. • Empty the urine bag. • Measure the output, if necessary. 	<p>Appropriately skilled professional staff (which, in this case, is restricted to licensed nursing staff acting within their scope of practice) will perform the following functions:</p> <ul style="list-style-type: none"> • Catheter insertion and removal. • Catheter irrigation.

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Condition	Regulatory Reference	Direct Care Staff Tasks ¹	Appropriately Skilled Professional Tasks ²
3) Residents requiring Intermittent Positive Pressure Breathing (IPPB) treatments.	Title 22, CCR, §87704. Applies to IPPB treatments, nebulizers and metered-dose inhalers (as appropriate).	<p>Trained direct care staff may assist residents with the self-administration of IPPB, nebulizer or metered-dose inhaler treatments as follows:</p> <ul style="list-style-type: none"> • Read instructions to the resident. • Open packaging. • Turn the power on or off. • May place a packet of pre-mixed, pre-measured medication (a “pillow”) into the chamber (but cannot mix medications, or mix medications with saline). • Steady the resident’s hand. • Ensure that the resident does not exceed the number of metered-dose inhaler “puffs” as identified on the ISP. 	<p>Appropriately skilled professional staff will assist with (or administer) IPPB, nebulizer or metered-dosed inhaler treatments, when the resident is not able to self-perform, as follows:</p> <ul style="list-style-type: none"> • Mix medications, or mix medications with saline. • Determine the need for a PRN (i.e., “as needed”) treatment.
4) Residents with either a colostomy or ileostomy	Title 22, CCR, 87705.	<p>Trained direct care staff may assist the resident as follows:</p> <ul style="list-style-type: none"> • Perform routine hygiene care, including bathing. • Empty the ostomy bag. • Measure the output, if necessary. • Change the ostomy bag. • Change the dressing or the adhesive pad to which the bag is affixed. 	<p>Appropriately skilled professional staff (which, in this case, is restricted to licensed nursing staff acting within their scope of practice) will assist as necessary with:</p> <ul style="list-style-type: none"> • Nursing assessment of ostomy status. • Any aspects of ostomy care as necessary.

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5) Residents with contractures.	Title 22, CCR, §87709.	Trained direct care staff may assist residents with: <ul style="list-style-type: none"> • Positioning and support. • Range-of-motion exercises. • Other prescribed exercises as per the ISP. 	Appropriately skilled professional staff will provide training for direct care staff to perform contracture care as described.
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Condition	Regulatory Reference	Direct Care Staff Tasks ¹	Appropriately Skilled Professional Tasks ²
6) Residents with diabetes.	Title 22, CCR, §87710, which states in (a): “The licensee shall be permitted to accept or retain a resident who has diabetes if the resident is able to perform his/her own glucose testing with blood or urine specimens, and is able to administer his/her own medication including medication administered orally or through injection, or has it administered by an appropriately skilled professional.”	Trained direct care staff may assist the resident to perform his/her own blood-glucose testing by providing the following assistance: <ul style="list-style-type: none"> • Read instructions to the resident. • Steady the resident’s hand (cannot press down on the device to prick the skin). • Read the number on a blood-glucose testing device for the resident (cannot interpret the number). • Open a packaged syringe and hand it to the resident. • Call the resident’s physician if the measured blood sugar is above or below the threshold specified on the ISP. 	Appropriately skilled professional staff (which, in this case, is restricted to licensed nursing staff acting within their scope of practice) will perform the following tasks if the resident is not able to self-perform: <ul style="list-style-type: none"> • Interpret the blood-glucose reading. • Determine the amount of medication to be given. • Inject medication into the resident. • Make nursing assessments or determinations as necessary.
7) Residents requiring enemas and/or suppositories.	Title 22, CCR, §87706.	Trained direct care staff may assist the resident by providing the following assistance: <ul style="list-style-type: none"> • Unwrap a medication. 	Appropriately skilled professional staff (which, in this case, is restricted to licensed nursing staff acting within their scope of practice) may administer

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		<ul style="list-style-type: none"> • Hand it to the resident. • Read instructions to the resident. • Help position the resident to self-administer the medication. <p>May steady the resident's hand, but cannot insert medication.</p>	<p>enemas or suppositories or provide the following assistance to the resident: Place a medication into a body cavity or penetrate an orifice.</p>
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Condition	Regulatory Reference	Direct Care Staff Tasks ¹	Appropriately Skilled Professional Tasks ²
8) Residents with incontinence of bowel and/or bladder.	Title 22, CCR, §87708.	Trained direct care staff may assist residents with incontinence care as consistent with full assistance with the management of ADLs. The resident will have a comprehensive, structured bowel and bladder-training program in the ISP.	Appropriately skilled professional staff will develop the bowel and/or bladder program and provide training for direct care staff to implement the program.
9) Residents requiring intramuscular, subcutaneous or intradermal injections.	Title 22, CCR, §87711, which states in (a): "The licensee shall be permitted to accept or retain a resident who requires intramuscular, subcutaneous or intradermal injections if the injections are administered by the resident or by an appropriately skilled professional."	Trained direct care staff may assist residents with the self-administration of injectable medications as follows: <ul style="list-style-type: none"> • Open pre-packaged medications. • Read instructions to the resident. <p>May steady the resident's hand, but cannot administer the injection.</p>	Appropriately skilled professional staff (which, in this case, is restricted to licensed nursing staff acting within their scope of practice) will administer the injection, or assist the resident as necessary.
10) Residents with Stage 1 or Stage 2 pressure sores (dermal	Title 22, CCR, §87713. (Note: The licensee must obtain prior approval from the licensing agency <u>to ensure compliance</u>	Trained direct care staff may assist residents with the following care: <u>For Stage 1 ulcers:</u>	Licensed nursing staff are required to provide the following skilled nursing care: <ul style="list-style-type: none"> • Apply medicated prescription creams.

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ulcers).	with Section 87702.1(a).) Residents must have the condition diagnosed by an appropriately skilled professional.	<ul style="list-style-type: none"> • Assist with, or apply, nonprescription or “barrier” creams. • Assist with the application of medicated, prescription creams. • Assist with, or apply, simple dressing changes, such as a pre-packaged medicated bandage. <p><u>For Stage 2 ulcers:</u></p> <ul style="list-style-type: none"> • Assist the resident with the application of medication or medicated bandages. <p>Assist with simple dressing changes.</p>	<ul style="list-style-type: none"> • “Pack” a wound. • Assess the status of a Stage 2 ulcer at least weekly. • Apply medication, or medicated bandages, to a Stage 2 ulcer when the resident is not able to self-administer with assistance. <p>Change dressings for a Stage 2 ulcer when the resident is not able to self-perform with assistance.</p>
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Condition	Regulatory Reference	Direct Care Staff Tasks ¹	Appropriately Skilled Professional Tasks ²
11) Residents who require wound care.	Title 22, CCR, §87713. (Note: The licensee must obtain prior approval from the licensing agency <u>to ensure compliance with Section 87702.1(a).</u>)	Trained direct care staff, under the direction of an appropriately skilled professional, may assist residents with wound care as per the ISP.	Appropriately skilled professional staff (which, in this case, is limited to licensed nursing staff acting within their scope of practice) will perform all dressing changes and wound care management that the resident is unable to complete by him/herself with the assistance of direct care staff as specified.

All care provided by an appropriately skilled professional, including skilled nursing care provided by licensed nursing staff, will be documented in the resident’s file. These records will be available for inspection by the CDHCS and the CDSS upon verbal or written request.

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Definitions of terms are as follows:

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- ²Appropriately Skilled Professional: As defined in Title 22, CCR, Section 87101(a), “appropriately skilled professional” means: “an individual that has training and is licensed to perform the necessary medical procedures prescribed by a physician. This includes but is not limited to the following: Registered Nurse (RN), Licensed Vocational Nurse (LVN), Physical Therapist (PT), Occupational Therapist (OT) and Respiratory Therapist (RT). These professionals may include, but are not limited to, those persons employed by a home health agency, the resident, or facilities and who are currently licensed in California.”

11. APPENDIX III – RATE SCHEDULE

The following is the rate schedule for the Assisted Living Services:

<u>Service</u>	<u>Amount</u>
■ Tier 1	\$52/participant/day
■ Tier 2	\$62/participant/day
■ Tier 3	\$71/participant/day
■ Tier 4	\$82/participant/day